FINANCING PATIENT EDUCATION

Financing Patient Education
Excerpts from:
Managing Hospital-Based Patient Education
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and
Financing Patient and Family Education at the Hospital Level
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In the past, whatever health/patient education received ("whenever" and "if ever,") was received when we went to the doctor's office, a clinic, or a hospital. Now we are being encouraged to take the "whatever, whenever, and if ever" out of patient education and we are being encouraged to provide education that is "for sure," consistent, organized, and accountable.

Clinic Health Directors and Hospital Administrators are encouraged to look at what they are doing now and many are saying, "To do this right is going to cost money; who is going to pay for it?" The fact that patient education can also contribute to cost containment is of little help at first, because it usually does require money (in terms of more staff time, and in many instances -- more staff) to bring patient education to reality.

Current Status of Reimbursement for Patient Education Services

Although the financing of health care has changed substantially since the landmark document *Financing for Health Education in the United States* was written in 1980, there has basically been little change in the overall status of reimbursement for patient education. Patient education that is integral to care, part of the treatment plan, and delivered under the supervision of a physician has been and continues to be allowable as an administrative expense under nearly all third-party payer policies; yet it is still rare to find specific patient education programs, other than diabetes patient education, reimbursed as a separate service.

Although *Current Procedural Terminology* (CPT) codes currently exist for group counseling sessions, most public and private insurance plans do not provide separate coverage for these services. Codes only establish a mechanism for billing; they cannot guarantee third-party reimbursement.

Medicaid: Medicaid is the federal-state government program that finances health care for specified low-income individuals. By federal mandate, certain basic services must be offered by states to all categorically needy Medicaid enrollees.

Several key reimbursement problems are specific to Medicaid. First, many states have set reimbursements rates so low that hospitals and clinics lost money for every Medicaid patient they service. It is currently estimated that on the average Medicaid pays $.80 for every dollar of care provided. Second, the Medicaid programs currently cover a smaller and smaller percentage of those below the federal poverty level; in 1976 35 percent of such persons were not covered. By 1991, this figure had soared to 60 percent. Therefore, no matter what policies the actual state Medicaid programs chooses to implement, a growing percentage of the poverty population has no coverage for basic medical care, let alone patient education services.

Medicare: Medicare is the federal government program that provides health care to elderly and disabled individuals. Since its inception in 1965, Medicare reimbursements have been limited to care that is "reasonable and necessary for the treatment of an illness or injury." In general, Medicare does not cover primary preventive services for people who are well.

Although more than 450 Bills have been introduced since 1965 that have sought to add various preventive benefits under the Medicare program, the only Bills that have been enacted reflect a bias toward immunization and screening rather than education and counseling. Currently the only preventive services covered broadly include immunizations for beneficiaries at high risk of contracting hepatitis B, Pneumococcal pneumonia immunizations, pap smears, and mammograms.

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Medicare will expand access to preventive services for eligible patients using Federally Qualified Health Centers receiving a grant under Sections 329, 330, and 340 of the Public Health Service Act. According to regulations published in the June 12, 1992 *Federal Register*, preventive primary services - including nutritional assessment, preventive health education, and immunizations - will be covered when provided in these settings. Specifically excluded are group or mass information programs, health education classes, or group education activities including media productions and publications.

The introduction in 1983 of the prospective pricing system and diagnosis-related groups (DRGs) essentially put an end to hopes that inpatient education might be reimbursable as a separate line item. Concern about patients being discharged "quicker and sicker," however, has resulted in more attention being paid to discharge preparation. Although never enacted, legislation introduced in 1992 - the Medicare Prevention Benefits Act - would provide reimbursement for risk assessment, preventive interventions, and counseling for persons first becoming eligible for Medicare.

As with Medicaid programs, hospitals and clinics can expect to lose a significant amount of money caring for Medicare patients. Newly released data suggests that hospitals and clinics can expect to pay out more than they receive for taking care of hospitalized Medicare patients.

Private Health Insurance Plans

Traditionally, private health insurance plans have covered patient education and related services in one of four ways. Most commonly, such services have been covered through incorporation into administrative costs. Less frequently, insurers have offered a benefit package that includes specified patient education benefits, for example, cardiac rehabilitation. They may also offer incentives to maintain healthy behavior or provide health education program.

In 1991, Blue Cross and Blue Shield Association issued guidelines designed to serve as the basis for a model preventive services benefit. Based on screening guidelines developed by the U.S. Public Health Service and the American College of Physicians, coverage includes well-baby care, childhood immunizations, and routine adult medical screening tests for cancer, heart disease, and other preventable illnesses.

Statements made by various health insurance groups all agree that patient education that is integral to the patient's treatment plan is a legitimate cost of patient care and should be reimbursed under existing reimbursement mechanisms. Many hospitals and clinics have interpreted this to mean that separate charges could be made for patient education and reimbursed by third-party payers. Some hospitals and clinics have hired "patient educators" to teach patients on a referral basis and established a charge of something like $10 per hour for this service. This method of improving patient education has disadvantages -- only one of which is that the charge is not usually reimbursable and the patient is then required to pay for it out of pocket.

If you talk to a major third-party payer and ask if they cover patient education, they will probably say, "Yes, we do. We consider patient education to be a basic part of patient care and we have always reimbursed for it through the basic rate. If we paid for it as a separate charge, we would be paying for it twice." They know that in reality education may or may not be provided but they shrug and state they are already paying for patient education.

Although there has been some disagreement about how this cost should be reimbursed, most insurance companies have agreed that any increased costs for patient education should be incorporated into the hospital or clinic's normal charge or rate. "If it costs more money - change the rate but not the rate structure. If it means increasing the education budget or the patient care budget, do it, and let it be subjected to the same scrutiny as all other elements of reimbursement."

Strategies to Increase Third-Party Reimbursement

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Although the overall third-party reimbursement climate is not favorable for the separate reimbursement of patient education, there are some opportunities to increase payments for services that are largely education in nature. The following five steps offer suggestions on assessing opportunities for reimbursement.

1. *Assess extent of current patient education reimbursement.* This first step involves data collection to determine the current status of reimbursement for patient education services offered by the hospital or clinic. The following data should be gathered:

   • What charges are currently generated from patient education services?
   • Are any of the charges for patient education service submitted for third-party reimbursement?
   • Of the charges submitted for third-party reimbursement is any portion reimbursed?
   • Do any of the managed care contracts negotiated by the hospital include PFCE services? If so, was any consideration given to the amount of resources required to implement these services?
   • Does the Health Director/Administrator think it would be useful to pursue additional reimbursement for patient education services?

2. *Assess the overall payer environment*. This information is critical to identifying opportunities for potential expansion of reimbursement. Strategic planning may have identified data regarding local employers and their health care benefit plans. The Chamber of Commerce may be sources of local employer information. State, local and county health departments may provide data on the existence of state-mandated benefits. The following data should be gathered:

   • What is the clinic or hospital's payer mix? Are patients primarily covered by public programs, or is there substantial private coverage?
   • Who are the largest insurers for the clinic or hospital's major services? Be as specific as possible.
   • Do any employer groups comprise a significant component of the clinic or hospital's inpatient or Outpatient caseload?
   • To what extent is managed care plans a significant component of the clinic's market share?
   • How are EPSDT services provided in the community? EPSDT: Under the Early Periodic Screening, Diagnostic, and Treatment Program enacted by Congress in 1967, states are required to provide health assessments and examinations and immunizations to all Medicaid-eligible children under the age of 21. Many states have done a limited job of informing eligible parents of the availability of this program, and restrictions on access to services and provider qualifications have limited the number of children receiving services.
   • Are there state-mandated patient education prevention service benefits?
   • To what extent are the major employers, including the hospital, self-insured?
   • To what extent do the physicians on the staff offer patient education services, and to what extent are they reimbursed for them?

3. *Assess payer interest*. Although the third-party payer policies represent overall directions for reimbursement, individual commercial insurers and individual insurance companies set local priorities. State Medicaid plans differ, and the fiscal intermediaries for Medicare often interpret regulations different. Any initial strategy in reaching theses payers is to meet with the appropriate staff members to gather the following information:

   • How does each payer view the scope and importance of patient education?
   • Does the payer reimburse for an education service, such as a smoking cessation program, if it is a part of cardiac rehabilitation?
   • Would the payer consider reimbursing for a patient education service in the future?
   • Would the payer consider a pilot project to look at such reimbursements?
   • Do local payers offer patient education or health promotion services directly to subscribers? If so, is there an opportunity to contract with hospital or clinic staff as providers?

   • Are local payers willing to support hospital or clinic-sponsored patient education or community health education programs through financial or in-kind contributions?

2. *Focus on patient education services with a high likelihood for reimbursement.* Reimbursement is

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most likely for outpatient chronic disease services that seek to ensure that the patient and family have the skills they need to manage the condition in question.

5. *Integrate patient education into outpatient care*. A large percentage of outpatient education services are activities that should be integrated into the routine delivery of outpatient care, especially primary care. Quality patient education requires assessment, problem solving, and reinforcement over time at every visit. The clinic or hospital staff should examine their current services to ensure that these services are integrated efficiently and consistently. No third-party payer will seriously consider any present or future reimbursement unless it can be demonstrated that patient education occurs on a planned, consistent basis.

Strategies to Increase Resources

1. Clarify the hospital or clinic's financial goals
2. Specify needed resources
3. Increase administrative support for patient education.
4. Identify other management opportunities to influence the budget
5. Increase efficiency
6. Collaborate internally and externally
7. Diversify by tapping into other funding sources
8. Train volunteers

When we talk about improving patient and family education, we are not referring only to special disease categories such as diabetes. Patient education means clear and complete information exchanged between all patients and all staff members during the routine course of treatment -- when a new procedure is about to be performed, when the patient is being screened, or when a patient asks a question. It means making sure that the patient knows about home care, and it means documenting this on the chart in a meaningful way.

Improved patient education is achieved in a number of ways:

(1) by helping staff stay up-to-date in the various diseases and conditions of the patients they treat so that they are comfortable with the content of what patients need to know;
(2) by helping staff become more sensitive to patient education and information needs and better able to communicate with patients;
(3) by organized responsibility with multidisciplinary involvement -- to insure that all patients receive the education they need with no contradictions and no gaps;
(4) by hospital or clinic administrative commitments.

One additional consideration needs scrutiny and this concerns the employment of a full-time “Patient Educator” versus patient education being provided by all the staff.

Sometimes a facility hires a full-time “Patient Educator,” usually a nurse or health educator, with the responsibility of patient teaching. Some see patients on a referral basis and make a separate charge. In most instances, this has been found to be very limited because they can only see a few patients a day and it sometimes actually deprives many patients of instruction they would have received prior to the employment of a full-time Patient Educator. The result is that staff who would routinely have provided this service (when they had time) discontinued any attempt to teach the patients because it was now somebody else’s job. Hospitals and clinics that employ such a position are in the process of changing to a true collaboration role where the educator works primarily with staff in organizing and supporting education efforts and in identifying education needs at the hospital or clinic-wide level so that activities/efforts can be directed toward meeting the most critical areas of need.

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The same general rules for outpatient services apply with third-party coverage. If the charge for education is built into the basic service or visit charge, it should be eligible for reimbursement as any other basic service charge and should be considered on the same basis as an inpatient charge. Medicare has indicated that they expect to pay for education on an outpatient basis or even home visits just as they would for inpatients if the education is integral to the treatment plan.

Part of our problem is that we do not figure in the educational or communication time involved in treatments and procedures when we establish fees for outpatient services. Further, most Administrators do not set aside any funds for patient education even though they assume that the clients using their facilities are receiving patient education.

Hospital and Clinic Administrators need to consider taking a certain percentage right off the top of the budget that could be allocated to patient education services. Hospital and Clinic Administrators also need to consider billing for other services, such as nutrition counseling -- especially if the nutritionist is a licensed or Registered Dietitian. There are some private insurance companies that will reimburse for certain types of patient education/counseling **IF** the provider is licensed or registered in their profession.

Finally, Institutions need to eliminate the use of the phrase; “I don’t have time to teach because I’m busy treating other patients.” Education is treatment. If a person is sick with an infection, the treatment is antibiotics; if the person is sick because of ignorance, the treatment is education.

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Diabetes Reimbursement

Coverage of Diabetes Outpatient Self-Management Training Services: Effective July 1, 1998
The Balance Budget Act of 1997

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of diabetes outpatient self-management training services when these services are furnished by a certified provider who meets certain quality standards.

A diabetes outpatient self-management and training service is a program which education beneficiaries in the successful self-management of diabetes. An outpatient diabetes self-management and training program includes education about self-monitoring of blood glucose, diet, and exercise, an insulin treatment plan developed specifically for the patient who is insulin-dependent, and motivates patients to use the skills for self-management.

Outpatient self-management training services may be covered under Medicare only if the physician who is managing the beneficiary's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the beneficiary's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) in the management of the beneficiary's condition.

Certified Providers: The statute states that a "certified" provider is a physician or other individual or entity designated by the Secretary that, in addition to providing outpatient self-management training services, provides other items and services for which payment may be made under Title XVIII, and meets certain quality standards. For initial implementation of this benefit we are designating as a certified provider those physicians, individuals or entities that are paid under the physician-fee schedule. These certified providers must meet the National Diabetes Advisory Board Standards (NDAB) as subsequently revised.

Along with physicians we will designate as certified providers other nonphysician practitioners who meet NDAB standards and whose services are paid for under the physician's fee schedule. These services may be provided in two ways:

1) First, the services performed by non-physician practitioners may be incident-to a physician's professional services, must be an integral, although incidental part of the physician's personal professional services, and must be performed under the physician's direct personal supervision.
2) Second, a non-physician practitioner such a Physician Assistant or Nurse Practitioner may be licensed under State law to perform a specific medical procedure and may be able to perform the procedure without a physician's supervision and have the services separately covered and paid for directly by Medicare as a Physician's Assistant or Nurse Practitioner service. Medicare only covers procedures and services that are performed in accordance with State license.

In keeping with the requirements of the legislation, services provided by individuals other physicians will be covered when they are provided within the current coverage requirements. These include: Physician Assistants (PAs), Nurse Practitioners (NPs), Nurse Midwives (NMs), Clinical Psychologists (CPs), and Clinical Social Workers (CSWs).

HCFA-Pub. 60-AB
The rules for Billing and payment to Non-Physician Practitioners Providing Diabetes Outpatient Self-Management and Training.

Employers of PAs must bill Part B of the Medicare program for professional services furnished by the PA, as well as services furnished as an incident-to the professional services of a PA. The PA's physician supervision (or a physician designated by the supervising physician or employer as provided under State law or regulation) is primarily responsible for the overall direction and management of the PA's professional activities and for assuring that the services provided are medically appropriate for the patient. Pursuant to section 4512 (c) of the Balanced Budget Act Medicare payment for PA services is made only to the PA's employer regardless of whether the PA is employed as a W-2 employee or whether the PA is

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acting as an independent contractor. Also, while a PA has an option in terms of selecting employment arrangements, only the employer can bill a carrier or intermediary for the PA's services.

Any service furnished by a PA must be furnished under the general supervision of a physician. General supervision does not require the physician to be present on the premises and immediately available while all services are being furnished. Rather, the physician may be reached by telephone in care of an emergency. However, any services furnished incident-to the professional services of the PA must be furnished while the PA is present on the premises and immediately available in case of an emergency while these ancillary services are being furnished. Accordingly, any service furnished incident to the professional services of a PA must comply with all of the "incident-to" requirements mentioned above.

Clinical Nurse Specialist's and NPs may bill the Medicare Part B program directly for services that are performed in collaboration with a physician. They may also bill the program directly for services furnished as an incident to their professional services in which case the direct supervision requirement in particular and all the incident-to requirements apply.

We are requiring that CNs, NPs, and the employers of PAs must submit claims to the Part B carrier under their own respective billing numbers for their professional services furnished in facilities or toerh provider settings except in the case where the services of these nonphysician practitioners are furnised to patients in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). Payment for these services of these nonphysician practitioners in the RHC/FQHC setting is bundled under the facility cost payment that is made by the intermediary under the all inclusive rate.

Coding and Payment: When a provider bills for diabetes self-management training services they should use the following CPT codes:

G0108 – Diabetes outpatient self-management training services, individual session, per 60 minutes of training.

G0109 - Diabetes outpatient self-management training services, group session, per 60 minutes of training.

We will allow $55.41 (practice expense relative value unit (RVU) of 1.51) per hour for an individual session and $32.62 (RVU of .89) per beneficiary per hour in a group session. Like other services paid under the physician fee schedule, the actual payment amounts will vary among geographic areas to reflect differences in costs of practice as measured by the Geographic Practice Cost Indexes.

Standards that certified providers must meet: (Currently under revision)

1. Structural Standards

   A. Organizational Support by Sponsoring Organizations
      - Standard 1: Maintain written policy affirming education as an integral component of diabetes care.
      - Standard 2: Provide education resources needed to achieve objectives for target population, including adequate space, personnel, budget and instructional materials.
      - Standard 3: Clearly define and document organizational relationships, lines of authority, Job descriptions, staffing, and operational policies.

   B. Community Needs Assessment
      - Standard 4: Assess service area to define target population and determine appropriate Allocation of personnel and resources

   C. Program Management
      - Standard 5: Establish standing advisory committee including at least a physician, nurse Educator, dietitian, behavioral science expert, consumer, and community Representative to oversee the program.
      - Standard 6: The Advisory committee should participate in annual planning to determine Target population, program objectives, participant access, and follow-up

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Mechanisms, instructional methods, resource requirements and program Evaluation.

- Standard 7: Professional program staff should have sufficient time and resources for Lesson planning, instruction, documentation, evaluation and follow-up.
- Standard 8: Assess community resources periodically.

D. Program Staff

- Standard 9: Designate a coordinator responsible for program planning, implementation, and Evaluation.
- Standard 10: Program instructors should include at least a nurse educator and dietitian with Recent didactic and experiential training in diabetes clinical and educational Issues. Certification as a Diabetes Educator by the National Certification Board of Diabetes Educators is recommended.
- Standard 11: Professional program staff should obtain continuing education about diabetes, Educational principles, and behavioral change strategies.

E. Curriculum

- Standard 12: The program must be capable of offering, based on target population needs, Instruction in the following 15 Content Areas:
  1. diabetes overview
  2. stress and psychosocial adjustment
  3. family involvement and social support
  4. nutrition
  5. exercise and activity
  6. medications
  7. monitoring and use of results
  8. relationships among nutrition, exercise, medication, and glucose levels
  9. prevention, detection and treatment of acute complications
  10. prevention, detection and treatment of chronic complications
  11. foot, skin, and dental care
  12. behavior change strategies, goal setting, risk factor reduction, and problem-solving
  13. benefits, risks and management options for improving glucose control
  14. preconception care, pregnancy, and gestational diabetes
  15. use of health care systems and community resources
- Standard 13: Use instructional methods and materials appropriate for the target population.

F. Participant Access

- Standard 14: Establish a system to inform the target population and potential referral sources of availability and benefits of the program.
- Standard 15: The program must be conveniently and regularly available.
- Standard 16: The program must be responsive to requests for information and referral sources Of availability and benefits of the program.

II. Process Standards

A. Assessment

- Standard 17: Develop and update an individualized assessment for each participant, including

  Medical history and health status; health services utilization, risk factors; diabetes

  Knowledge and skills; cultural influences; health beliefs; attitudes; behavior and

  Goals, support systems; barriers to learning; and socioeconomic factors.

B. Plan and Implementation

- Standard 18: Develop an individualized education plan, based on the individualized assessment,

  In collaboration with each participant.

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- Standard 19: Document the assessment, intervention, evaluation, and follow-up for each Participant, and collaboration and coordination among program staff and other Providers, in a permanent record.

B. Follow-Up
- Standard 20: Offer appropriate and timely educational interventions based on periodic Reassessments of health status, knowledge, skills, goals, and self-care behaviors.

III. Outcome Standards
A. Program
- Standard 21 The advisory committee should review program performance annually, and use The results in subsequent planning and program modification.

B. Participant
- Standard 22: The advisory committee should annually review and evaluate predetermined Outcomes for program participants.

Carrier Billing Requirements
Providers should bill for their professional services using CPT code G0108 and G0109 on the form HCFA-1500. When billing for these codes the certified provider must on the first claim, provide you with a copy of its "Certificate of Recognition" from the American Diabetes Association that affirms they are a recognized provider. For the initial office visit the provider should bill an evaluation and management code. Thereafter, one of the new diabetes self-management education codes should be used. The statute requires that physicians and other individuals must provide other items and services for which payment may be made under title XVIII. However, this does not prevent new physicians or entities who did not previously possess a billing number from simultaneously obtaining a billing number and becoming a certified provider.

Apply the deductible and coinsurance.

Billing Requirements for Intermediaries
The provider bills for diabetes self-management training services on the HCFA-1450 or its electronic equivalent. The cost of the service is billed under revenue code 51X in FL 42 "Revenue Code." The provider will report CPT codes G0108 or G0109 in FL 44 "HCPCS/Rates." The definition of the CPT codes used should be entered in FL 43 "Description." As mentioned above, when a provider bills for these codes, they must on the first claim, provide you with a copy of its "Certificate of Recognition" from the American Diabetes Association that affirms they are a recognized carrier.

Apply the deductible and coinsurance.

Applicable Bill Types

The appropriate bill types are 11X, 12X, 13X, 71X, (Provider-based and independent), 72X, 73X, (Provider-based and freestanding), 83X and 85X.

Medicare Summary Notice (MSN) and Explanation of your Medicare Benefits (EOMB) Messages
Intermediaries and carriers that have not yet converted to MSN should utilize the following EOMB messages.

Intermediaries who have converted to MSN should utilize the following EOMB messages.

If the claim is denied because the procedure code or revenue is invalid, use the following message:

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“The item or service was denied because the information required to make payment was incorrect.” (MSN message 9.4) or “Medicare cannot pay for this because your provider used an invalid or incorrect procedure code and/or modifier for the service you received. (EOMB message 9.21)